The evidence of meningitis at the necropsies was extremely variable, not only in extent but in type. The vertex and anterior fossæ were involved in but few of the cases; in the majority it was confined to the base. In some of the deeply-seated old temporo-sphenoidal abscesses with smooth thick walls and a covering of apparently healthy cortex, there were no signs of meningitis either focal or diffused, while in others of the same type the whole sub-arachnoid space was filled with a turbid and fœtid fluid containing many varieties of bacteria, but no cells except a few lymphocytes.

In addition to the diagnostic aspects of lumbar puncture in these cases, one must not overlook the therapeutic value, as it not only removes bacteria and their toxins, dead cells with their tryptic products from the spinal cord, but has in several cases afforded striking and immediate relief to the characteristic pressure symptoms of tubercular meningitis which complicated the aural trouble.

Finally, it must not be forgotten that in acute cases a second or even a third "tap" may be necessary to afford positive evidence of infection.

HERPES ZOSTER OTICUS.

By A. R. Tweedie, F.R.C.S.,
Nottingham.

In connection with the case shown by Dr. H. J. Davis at the meeting of the Otological Section of the Royal Society of Medicine on February 20, 1914, and the editorial on the subject in the following June number of this Journal, the following two cases may be of sufficient interest for publication and record.

Miss M——, aged forty-seven, was sent to me November 20, 1911, with the story that on September 20 of that year she visited her sister-in-law in Stirling, and fourteen days later had an attack of "shingles" involving the back of the head, the neck, the auricle, and lower part of the face on the left side. This was accompanied by deafness and giddiness, tendency to fall to the left, and later followed by paralysis of the left facial nerve. (It is interesting to note in passing that her sister-in-law had had an attack of "shingles" on her body some three months earlier, as this disease has been known at times to exhibit an apparent seasonal or epidemic incidence.)

On examination the nose, pharynx, and naso-pharynx were

https://doi.org/10.1017/S1755146300015122 Published online by Cambridge University Press

found normal and healthy. The teeth required attention. There was a large, old, inferior defect in the right tympanic membrane, now quiescent, attributed to an attack of scarlet fever thirteen years ago, otherwise this ear was healthy. On the left side the external effects of the herpetic eruption had disappeared, but examination of the aural fundus showed an opaque drumhead with a rough glistening surface and marked injection of the malleolar plexus. Range for whisper on this side, 7 yds. No spontaneous nystagmus or deviation. No antral or mastoid tenderness. Total paresis of the left facial nerve. During the deafness at the commencement of the attack the patient volunteered that "voices appeared shrill." (Was this in any way associated with paresis of the stapedius muscle?)

She was already having electrical treatment when I saw her, and I advised that this should be continued. Her recovery was slow, but by March of the following year the paresis was much improved and in another three months all symptoms had disappeared. As far as is known she had and has had no further attack.

Mrs. S——, aged thirty, came to see me January 2, 1912. She was the wife of a doctor who stated that she had had earache on the left side on and off for the last fourteen days with a good deal of general malaise, and an herpetic eruption on the nose.

Nothing abnormal was found on examination of the interior of the nose, mouth, or throat, and the right ear was sound and healthy. On the left side the anterior auricular area and apex of the mastoid were tender; external otitis rather obscured the view of the fundus, but the tympanic membrane could be seen to be intact and mobile. Definite weakness in closing the left eye. The patient also said she had tingling over the back and side of her head on the left and noises on the same side "like a band playing," and giddiness. No spontaneous nystagmus or deviation or antral tenderness. Treatment on general lines and topical applications were suggested, and within a few days the pain and discomfort were very much relieved. A month later, however, she had a similar attack on the opposite side with noises, giddiness, and deafness lasting about fourteen days, during which small vesicles appeared on that drumhead. The acute symptoms soon subsided, but for many months she complained of intermittent smarting, stinging, and shooting in the ears, which apparently could be described as more annoyance than discomfort, but most irresponsive to local treatment and salicylates internally. It was some eighteen months or more before she thoroughly recovered.

https://doi.org/10.1017/S1755146300015122 Published online by Cambridge University Press

In both these cases the question of some inflammatory middle-ear lesion requiring operative treatment arose and was the chief reason for the consultation. This aspect of differential diagnosis was amply elaborated in the discussion of the Otological Section and the editorial above referred to, and does not here need repetition. One point, however, was apparently omitted which may deserve notice, that is the absence of middle-ear tenderness and pain on compression and aspiration. In each instance most of the typical signs of acute inflammatory otitis media were present, including in one case the appearance of the fundus, but the fact that here the membrane was freely mobile and movement was painless at once suggested a lesion limited to the drumhead and not involving the drum cavity.

SOCIETIES' PROCEEDINGS.

ROYAL SOCIETY OF MEDICINE—LARYNGOLOGICAL SECTION.

February 5, 1915.

Dr. WILLIAM HILL, *President of the Section, in the Chair.*

The After-treatment of Submucous Resection of the Nasal Septum without the Use of Splints.—Sir William Milligan.—Sir WILLIAM MILLIGAN said that at the last meeting of the Section Dr. Dan McKenzie showed new splints for the after-treatment of cases in which a submucous resection of the nasal septum had been performed, but he considered that if these cases could be treated without a splint at all it would be a considerable advantage. The comfort to the patient was undoubtedly greater, and continuous drainage from the nose was better ensured. For some time he had not used any splints. After the requisite bone and cartilage had been removed he use Whitehead's varnish,[1] a varnish used by Mr. Walter Whitehead after his operation for removing the tongue, painting it on the two perichondrial surfaces, and then bringing those surfaces together. It caused the muco-perichondrial surfaces to adhere. Though he had used this method for a considerable time, he had not seen a hæmatoma ensue in any case, and patients expressed their appreciation of being able to breathe through the nose immediately after the operation. The opinion of the nurses was that recovery was more rapid under this plan than when splints were employed.

Dr. WATSON-WILLIAMS said that when, as often happened, there were complicated conditions present, *e. g.* more or less active sinus trouble, packing of the nose was a cause of considerable anxiety; sometimes one did not know whether to deal with the septum or the sinus first. Again,

[1] Gum benzoin, 4 dr.; styrax, 3 dr.; socotrine aloes, 40 gr.; balsam of Tolu, 1 dr.; iodoform, 4 dr.; pure ether, 5 oz.

https://doi.org/10.1017/S1755146300015122 Published online by Cambridge University Press